. No. 2
—1/47
5-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 9 1948
Registration District No. 318

#80808

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 43139
Registrar's No. 11903

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4318 Maryland Avenue
Memorial 19
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOHN HOFFMEISTER
3. (b) If veteran, name war Nil
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 30 (Day) 1885 (Year)

8. AGE: Years 62 Months 4 Days 27 If less than one day hr. min.
9. Birthplace Franklin County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Unknown
11. Industry or business
FATHER
12. Name Fred Hoffmeister
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Wissinger
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Tillie Hulsey
(b) Address 1003 Armstrong Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (Month) (Day) (Year)
(c) Place: burial or cremation Grubville, Mo
18. (a) Signature of funeral director A W McLaughlin
(b) Address 2301 Lafayette
19. (a) DEC 29 1947 (Date received local registrar) (b) J A Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27th year 1947 hour 3 minute 20 P.M.
21. I hereby certify that I attended the deceased from 12/26/47, 19, to 12/27/47, 19; that I last saw him alive on 12/27/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis lenticulo striate artery, right with probable bleeding into right internal capsule.
Due to
Other conditions Hypertensive Cardiovascular disease.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature J W Kohler (M. D. or other)
Address 1515 Lafayette 12/29/47 Date signed

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....L P Cooper.....

Licensed Embalmer No. 3633

P. O. Address 3301 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

6. No. 2B
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11903

1. PLACE OF DEATH:

(a) County
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Hofmeester
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Wd
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 30 (Month) (Day) (Year)
8. AGE: Years 62 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country) Unknown No
10. Usual occupation
11. Industry or business
12. Name (FATHER)
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name (MOTHER)
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

JAN 14 1948

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month day year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

43139

L110-8